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ABSTRACT

Successful management of the elderly patient is related in part to how effectively he and members of the health care team can communicate with each other. If comprehension and/or expressive abilities are impaired, as they frequently are in the geriatric population, then efficient patient management becomes difficult. Unfortunately, this difficulty is often compounded by the staff members' lack of understanding about the extent of the patient's communication deficits. Consequently, the patient's communication abilities are either underestimated or overestimated, resulting in a number of problems which tend to increase management difficulties. In order to minimize these problems, the speech pathology service at the St. Boniface Hospital has implemented a training program designed to teach members of the health care team how to do a quick, simple and reliable assessment of their patients' basic comprehension and expressive skills for management purposes. This assessment procedure will be described with respect to its administration and practical interpretation. (Author)

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COMMUNICATION AND THE ELDERLY PATIENT

by

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COMMUNICATION AND THE ELDERLY PATIENT[1]

George Gasek, Ph.D.

Successful management of the elderly patient is related, in part, to how effectively he and members of the health care team can communicate with each other. In order for communication to be effective it is at least necessary that the patient comprehend what is being related to him and that he, in turn, is able to express his needs to others. If comprehension and/or expressive abilities are impaired, as they frequently are in the geriatric population, then efficient patient management becomes difficult. Unfortunately, this difficulty is often compounded by staff members' lack of understanding about the nature and extent of the patient's communication deficits. As a result, the patient's communication abilities are either underestimated or overestimated.

Underestimating a patient's communication abilities, particularly his comprehension, can have a detrimental affect on his psychological well-being and, consequently, on his management. For example, there is nothing so demoralizing and debasing to an adult than to be talked down to as if he were a child or imbecile. And yet, this is what all too often happens to the geriatric patient who is known to be, or thought to be, communicatively impaired. A related problem occurs when staff members, assuming that the patient does not comprehend anything that is said to him, indiscreetly talk about him in his presence -- a situation which

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[1]The text of this paper was presented at the Canadian Association on Gerontology Educational Meeting held in Vancouver, B.C. November 11 - 13, 1976.

frequently occurs during bedside rounds with the acute stroke patient. This situation can have unfortunate consequences for both patient and staff. The patient can become upset by the comments being made about him which results in increased management difficulties for the staff. On the other hand, the staff members involved in this indiscretion can be placed in an unpleasantly embarrassing position when, at a later date, the patient is capable of reminding them of their remarks about him.

Underestimations of patients' communication abilities can occur for a number of reasons. Depression or fright will often result in a reluctance to communicate. This reluctance may be misinterpreted by staff as a communication inability. Confusion and inattention can yield faulty impressions of communication skills. Similarly, personality, cultural and/or generational differences between patients and staff often contribute to communication problems which, in turn, might be misinterpreted as real disabilities. A more common reason why communication underestimations occur with the elderly patient is due to staff members' ignorance, or forgetfulness, of the simple 3S Rule, i.e., Keep it SHORT, SIMPLE and SLOW.

Many geriatric patients, particularly those with neurologically related language problems (e.g. stroke patients), cannot easily comprehend verbal information that: (a) is too long (non-stop conversation); (b) is presented too quickly; and/or (c) is too abstract, esoteric or contains idiomatic expressions and slang that is unfamiliar to the patient. Consequently, this comprehension difficulty may be viewed by staff as a true (pathologic) comprehension deficit resulting, in turn, in an underestimation of the patient's actual comprehension skills.

Thus, verbal information to such patients should be presented in a slow manner, using short phrases and relatively concrete language (e.g. using common, every day vocabulary which the patient is likely to understand). In addition, allowance must be made for increased response time to conversation and questions.

Overestimating the communication abilities of the elderly patient also has its problems. If on the basis of casual observation, an erroneous assumption is made that a patient's communication skills are normal, then staff members expect him to respond appropriately to their instructions. If he does not, they accuse him of being uninterested, unmotivated, stubborn and/or generally uncooperative. Such accusations are dangerous, especially if they are wrong, because they tend to be self-fulfillingly prophetic. That is, the staff begin developing the attitude about the patient that he is uncooperative and, consequently, start treating him negatively. The patient, in turn, reacts to these negative behaviors by becoming aggressive and increasingly uncooperative. The unfortunate end result of this downward attitudinal spiral is poor patient care.

This type of situation need not have occurred had the staff members avoided making assumptions of normal communication on the basis of casual and subjective observations -- one common reason for overestimation (and underestimation) errors. Experience has shown that upon closer systematic and objective examination, many such "uncooperative" patients demonstrate real communication deficits that are easily overlooked by casual observation. For example, many language impaired stroke patients are able to use automatic-social speech such as responding to, or initiating, greetings (e.g. "Hi";"How are you"); listening attentively to persons speaking

to them: nodding their heads affirmatively or answering "Yes" to questions posed to them. Since much of the communication that goes on between staff and patients is informal, automatic-social in nature and since most questions asked of patients are usually "Yes" questions, one can easily be misled into thinking that the patient's comprehension skills are pretty reliable. However, when asked to respond to questions such as "What would you like for dinner today" or "Where did you put your eyeglasses" they may just smilingly sit there nodding their heads and saying"Yes".

A second reason why staff members overestimate a patient's verbal comprehension skills is Verbal-Gestural Confusion. Although most of our daily communication is verbal in nature, we frequently employ gesture to emphasize or embellish what we are saying. In fact, we all do this very automatically. Thus, when a staff member says to a patient "Give me your hand, Mr. Jones" she frequently accompanies this request with an extended hand. Or, when the patient is asked to "Point to the window" the request is coincidentally associated with such gestural cues as pointing or nodding toward the specific window. If the patient responds appropriately to these requests, it is then assumed that his verbal comprehension is normal. However, such an assumption can be very wrong because verbal comprehension was not clearly and unambiguously being evaluated in these examples. One could easily have argued that the patient responded to the gestural and not the verbal cues -- a quite common situation among stroke patients. The important point of the above examples is that a patient's verbal comprehension abilities can easily be overestimated when the staff believe they are evaluating one

skill (verbal comprehension) when, in fact, they are assessing something else (gestural comprehension).

A third reason why staff members tend to overestimate a patient's communication abilities is due to what I call Situational Communication. Many communicatively impaired geriatric patients become easily confused, frightened and withdrawn when placed into a new environment. Fortunately, most of them begin to adapt to their surroundings, daily routine and staff within a few weeks. By the same token, the staff members adapt to the patient and his idiosyncracies. Before too long the staff report that the patient's overall communication skills are much improved; that he is able to understand and express all or most of his daily needs. However, when such a patient's communication abilities are evaluated objectively and systematically, it is found that no change has taken place in this regard. What has, in fact, happened is that the patient has become more responsive to attention, more alert and more cooperative. He has also learned to react to situational cues and routines in a fairly predictable manner. The staff members, on the other hand, besides being caught up in automatic-social communication and verbal-gestural confusions, have learned to comprehend the meaning of specific idiosyncratic gestures which initially were meaningless to them and continue to be meaningless to new staff. In addition, they have learned to anticipate certain needs that the patient frequently has. Subsequently, they confuse these anticipatory actions on their part with the expressive abilities of the patient. That is, they come to believe that the patient has, in fact, expressed these needs to them.

If members of the health care team are to be successful in their

management of the elderly patient they will need to establish effective communication with them. To do so, however, implies that they have a clear and accurate understanding of their patients' communication abilities. When the team includes a speech pathologist, acquiring this understanding usually poses little difficulty. Unfortunately, many such teams do not have available to them a speech pathology service. If it is available, there is often a long delay between the time the patient arrives on the ward or a nursing home and the time he can be seen for a comprehensive diagnostic evaluation of his communication abilities. Or, his communication skills are changing so rapidly, as is the case with many acute stroke patients, that a bedside communication assessment is required daily -- an impractical situation for many speech pathology services. Under these circumstances, it would be more practical if other members of the health care team, particularly the nursing staff, could assess patients' basic communication abilities for management purposes.

If such assessments are to circumvent the problems associated with underestimations and overestimations of communication abilities, they have to meet certain basic criteria. For one, they must be relatively quick and easy to administer. If the assessment entails too much time and/or requires extensive training to be able to administer it, then its practical utility is greatly diminished. Secondly, the assessment must be carried out systematically and objectively. A major problem with most informal or casual communication assessments is that they all too often are based on subjective impressions rather than objective

evidence. When objective information is sought it is usually done in an unsystematic, hit-and-miss fashion. This results in a confused picture of the patient's communication abilities. Also, such assessments are impossible to replicate. Consequently, assessment findings become unverifiable and any small changes which have occurred in a patient's communication status over a short period of time are difficult to detect. Finally, the assessment must be valid. That is, it must assess what it purports to assess. The verbal-gestural confusion problem cited earlier is an example of poor validity.

The speech pathology service at the St. Boniface General Hospital has effected a training program designed to teach other members of the health care team (nurses, physical and occupational therapists, social workers) how to do a quick, simple and reliable assessment of their patients' basic communication abilities for management purposes. Since the inception of the training program one year ago, problems of overestimations and underestimations of patients' communication skills have decreased while, at the same time, improved patient management has occurred.

A DESCRIPTIVE ASSESSMENT OF BASIC COMPREHENSION AND EXPRESSIVE ABILITIES

Instructions

It is recognized that geriatric patients may have impaired communication abilities for a variety of reasons, e.g., hearing losses, neurological deficits, visual problems, decreased memory, confusion, disorientation, visual-motor perceptual deficits. In order to determine the nature and extent of any given communication disorder, a complete diagnostic evaluation would have to be made by a speech pathologist. The assessment procedure presented below does not qualify as such an assessment. Rather, its sole purpose is to enable health care team members to obtain a descriptive picture of patients' basic comprehension and expressive abilities in order to help them better manage their patients.

General Considerations

1. If the patient is known to use eyeglasses or a hearing aid, be sure that they are functional and are worn during the assessment.

2. Many patients become confused, frightened or indignant and, consequently, uncooperative, if they are not informed about what they are expected to do and why.

Therefore, explain to the patient WHAT you are going to do and WHY -- even if you think the patient does not understand. For example.

"Mr. X, I am going to ask you to do some things so that I can tell if you may be having difficulty letting people know what you want or understanding what they are saying to you. Some of the things I will ask you to do are very easy while other things may be more difficult. I just want you to do the best you can."

3. Present all instructions SLOWLY. Allow the patient plenty of time to respond.

ASSESSMENT OF COMPREHENSION

The purpose of the comprehension assessment is to find out at what level of language complexity the patient reliably understands what is SAID (Verbal Comprehension), WRITTEN (Graphic Comprehension) and GESTURED (Gestural Comprehension) to him.

I. Verbal Comprehension

(a) Purpose: To find out at what level of language complexity the patient can reliably understand what is SAID to him.

(b) Equipment: Drinking Glass, Bar of Soap, Pen, Spoon. These four objects are placed in front of the patient in the following order from left to right: PEN, SOAP, GLASS, SPOON.

(c) Administration: Give, in turn, the one, two and three-stage verbal instructions and check the YES box if the patient's response to a given instruction was correct or the NO box if the response was incorrect or absent.

Note: If a patient does not perform well on the one-stage instructions then it is unlikely that he will do any better on the two and three-stage instructions. Therefore, they can be eliminated from the assessment for that patient. However, since it is presumed that he cannot complete these more complex instructions correctly, they are scored as incorrect.

(d) Results: If the patient does not respond to the verbal instructions or, his responses are inconsistently correct (less than 4 out of 4) at any one of the three stages, then his verbal comprehension is not reliable at that stage.

When a patient can only follow one-stage instructions reliably then staff members should talk to him at the simple one-stage level, e.g., 'turn over', "raise your arm", 'time to eat' etc. If such patients are given the more complex two and three-stage instructions they will become confused and frustrated. On the other hand, if a patient's verbal comprehension is reliable (4/4) at all three stages, then his comprehension of the spoken word is quite functional and he should have little or no difficulty understanding what is said to him.

II. Graphic Comprehension

(a) Purpose: To find out at what level of language complexity the patient can reliably understand WRITTEN information.

(b) Equipment: (1) Drinking Glass, Bar of Soap, Pen, Spoon. These four objects are placed in front of the patient in the following order from left to right: PEN, SOAP, GLASS, SPOON.

(2) The words GLASS, SPOON, SOAP, PEN printed in large black letters on four 3" x 5" index cards (one word on a card).

(3) The following four sentences printed in large black letters on four 3" x 5" index cards (one sentence on a card):

PICK UP THE SPOON
SHOW ME TWO FINGERS
PUT THE SPOON BETWEEN THE PEN AND THE SOAP
PUT THE GLASS TO THE LEFT OF THE PEN

(c) Administration:

Single Words (nouns) - Expose one card at a time to the patient and say: "Read this word and show me where one of these is" (gesture to the four items in front of him). Check the YES box if the patients response to a given word was correct or the NO box if the response was incorrect or absent.

Note: For a response to be marked as correct, the patient must show you the object to which the word refers.

Sentences - Expose one card at a time to the patient and say: "Read this sentence and do what it says to do". Check the YES box if the patient's response was correct or the NO box if the response was incorrect or absent.

Note: For a response to be marked as correct, the patient must perform the task indicated on the card.

(d) Results: In the Graphic Comprehension assessment the patient is asked to read nouns and sentences. In addition, he must be able to demonstrate his comprehension of the written material by acting on it, i.e. when shown the word PEN, the patient must be able to identify the object pen from among four objects placed in front of him. A patient's performance on each of these tasks is reliable when it is done correctly four out of four times.

Many language impaired or apraxic patients can read written instructions or words quite well but they cannot associate or act upon what was read. For example, they may read the word SPOON correctly but cannot identify the object spoon from among other objects. Similarly, they may correctly read aloud the sentences "Give me your hand" but cannot act upon the instruction i.e. giving you their hand. It is, therefore, important that the patient demonstrate what he has read in order to indicate that he understood the message. Otherwise, one can be easily misled into thinking that the patient's performance is better than it really is--a problem of overestimation. This type of overestimation error can have serious consequences. For example, patients have been known to overdose on self-administered prescription drugs because they really did not comprehend the written instructions, even though they read them correctly aloud.

III. Gestural Comprehension

(a) Purpose: To find out if the patient can understand information presented to him by means of visual demonstration or gesture.

(b) Equipment: Drinking Glass, Bar of Soap, Pen, Spoon, Comb. These five objects are placed in front of the patient in the following order from left to right: PEN, SOAP GLASS, SPOON, COMB.

Note: The comb is used as a demonstration item for this assessment to assist the patient in understanding the task which he will be required to do. It is not used in the YES/NO scoring.

(c) Administration: Pantomime the use of a comb for the patient i.e., pretend that you have a comb in your hand and you are combing your hair. Then, point to the comb located in front of the patient. Following this, pantomime the hair combing activity again and point to the comb. Finally, pantomime the combing activity and gesture to the patient to point to (or pick up) the correct object i.e. the comb.

If the patient responds correctly to the demonstration item (comb) then go on to the four Gestural Comprehension

assessment items. On the other hand, if his response to the demonstration item was incorrect or absent, then omit the gestural Comprhension items and scorethem all as NO.

Gestural Comprehension assessment items:

GLASS - Pantomime the activity of drinking from a glass (pretend that you have a glass in your hand and are drinking from it). Then, gesture to the patient to point to the appropriate object in front of him.

PEN - Pantomime the activity of writing with a pen (pretend that you have a pen in your hand and are writing with it). Then, gesture to the patient to point to the appropriate object in front of him.

SOAP - Pantomime the activity of washing hands with soap (pretend that you have a bar of soap in your hands and are washing them). Then, gesture to the patient to point to the appropriate object in front of him.

SPOON - Pantomime the activity of eating with a spoon (pretend that you have a spoon in your hand and are eating soup with it). Then, gesture to the patient to point to the appropriate object in front of him.

Check the YES box if the patient correctly identifies the pantomimed object or the NO box if his response was incorrect or absent.

(d) Results: Many language impaired patients are unable to understand spoken or written instructions very reliably. For such patients it is often necessary to use gestural cues or demonstration in order to get information accross to them. For example, rather than telling a patient how to use a wheelchair or how to transfer from wheelchair to bed, it is usually more expedient, and less frustrating to both the patient and staff if the steps and procedures involved are demonstrated to them in a step-by-step fashion. For some patients thismay be the only reliable form of comprehension.

A reliable performance on the Gestural Comprehension assessment is four out of four correct responses.

ASSESSMENT OF EXPRESSION

The purpose of the expression assessment is to find out at what level of language complexity the patient can reliably express his needs and wants by SPEAKING (Verbal Expression), WRITING (Graphic Expression) and GESTURING (Gestural Expression).

I. Verbal Expression

(a) Purpose: To find out at what level of language complexity the patient can express his needs and wants to others using SPEECH.

(b) Equipment: Drinking Glass, Bar of Soap, Pen, Spoon. These four objects are placed in front of the patient in thefollowing order from left to right: PEN, SOAP, GLASS, SPOON.

(c) Administration

Naming - Pick up each of the four objects, in turn as indicated on the Response Form and say "What is this" or "What is the name of this". Check the YES box if the patient's response was correct or the NO box if the response was incorrect or absent.

Describing - Pick up each of the four objects, in turn as indicated on the Response Form and say: "What is this used for." In order for a response to be marked YES, the patient must correctly describe the object's function. He can do this either with one word (e.g. "write" for PEN or "wash" for SOAP) a short phrase (e.g. "eat with" for SPOON or "drink water" for GLASS), or a complete sentence (e.g. "A pen can be used for writing letters, signing cheques or doodling" or "A spoon can be used for such things as eating soup, stirring tea or coffee, eating ice cream, etc". A response is marked NO if it is incorrect or absent.

(d) Results: For some patients, the only reliable verbal expressive skills they have are at the one word level. Thus, they may say "tired", "bed" or "sleep" to indicate that they want to go to bed. Staff members should encourage such patients to communicate at the one-word level, for it certainly is functional.

Other patients may be able to communicate at the simple phrase level (e.g., "want toilet" or "doctor here"). Again, if a patient's verbal expressive skills are reliable at this level, he should be encouraged to use these skills.

Finally, the patient may be able to verbally express his needs in a complete and detailed manner (e.g., "Nurse, would you please call the physical therapy department and tell them that I don't feel well and would rather not attend my therapy session today"). This type of patient would certainly have little or no difficulty telling others what he wanted.

By assessing a patient's verbal expressive skills, the staff members will know at what level of verbal expression (word, phrase, sentence) the patient functions most reliably and they will be better able to adapt themselves to that level - thereby meeting the patient's needs more effectively.

A reliable performance on the Verbal Expression assessment is four out of four correct responses.

II. Graphic Expression

(a) Purpose: To find out at what level of language complexity the patient can express his needs to others by WRITING.

(b) Equipment

(1) Drinking Glass, Bar of Soap, Pen, Spoon. These four objects are placed in front of the patient in the following order from left to right: PEN, SOAP, GLASS, SPOON.

(2) One #2 pencil and ruled writing paper.

(c) Administration

Naming - Put the writing paper in front of the patiet and place the pencil in his most functional (not necessarily dmoninant) hand. Pick up each of the four objects, in turn as indicated on the Response Form and say: "Write the name of this object on the paper". Check the YES box if the patient's response to a given object was correct or the NO box if the response was incorrect or absent.

A response is correct if the written word is clearly identifiable as the intended word. If in doubt ask yourself: "Could a person who is unfamiliar with this assessment correctly identify the written response without difficulty" If your answer to this question is YES, then the response is correct and the YES box should be checked. On the other hand, if there is any doubt about the written response or it is clearly unrecognizable or absent, then the response is incorrect and the NO box is checked.

Describing - Pick up each of the four objects, in turn as indicated onthe Response Form and say" "Write down on the paper what this object is used for". In order for the response to be correct, it must be ligible (see immediately above for instructions regarding legibility for words) and it must correctly describe the object's function. As in the case of Verbal Expression, the response can be either a single word, a short phrase or a complete sentence.

(d) Results: For some patients, the only reliable graphic

expressive skills they have are at the one word level. Other patients may be able to communicate graphically at the phrase level. Finally, some patients will be able to express their needs graphically in a complete and detailed manner. For those patients who cannot use the graphic modality to express themselves, they should not be expected to write down what they want.

Performance reliability on the Graphic Expression assessment is four out of four correct responses.

III. Gestural Expression

(a) Purpose: To find out if the patient can reliably express his needs by means of GESTURE.

(b) Equipment: Drinking Glass, Bar of Soap, Pen, Spoon, Comb. These five objects are placed in front of the patient in the following order from left to right: PEN, SOAP, GLASS, SPOON, COMB.

Note: The comb is used as a demonstration item for this assessment to assist the patient in understanding the task which he will be required to do. It is not used in the YES/NO scoring.

(c) Administration: Point to the comb and then pantomime its use for the patient, i.e. pretend that you have a comb in your hand and are combing your hair. Then, point to the comb again and repeat the hair combing pantomime. Finally, point to the comb and then gesture to the patient to pantomime its function i.e. combing hair.

If the patient responds correctly to the request, i.e. pantomimes the combing activity, then go on to the four Gestural Expression assessment items. On the other hand, if his response was incorrect or absent, then omit the remaining four items and score them all as NO. A response is correct if it is unambiguous and correctly identified with the specific object.

Gestural Expression assessment items:

SPOON - Point to (or pick up) the spoon and then gesture to the patient to pantomime its use.

SOAP - Point to (or pick up) the soap and then gesture to the patient to pantomime itsuse.

PEN - Point to (or pick up) the pen and then gesture to the patient to pantomime its use.

GLASS - Point to (or pick up) the glass and then gesture to the patient to pantomime its use.

(d) Results: If the patient's gestural expressions are reliable (correct four out of four times) and he has no other means of reliable expression, then he should be encouraged to use this form of communication to express many of his needs. This can be accomplished through pantomime or pictures* of common needs (e.g., toilet, bed, photograph of close relative, nurse or doctor) to which the patient or a staff member can point to.

*A small book of pictures and photographs can be made for such patients on an individual basis.

A DESCRIPTIVE ASSESSMENT OF BASIC

COMPREHENSION AND EXPRESSIVE

ABILITIES

Response Form

ASSESSMENT OF COMPREHENSION

I. Verbal Comprehension (Present all instructions SLOWLY and CLEARLY, allowing the patient plenty of time to respond. Be sure that you have given the entire instructions before allowing the patient to respond).

A. One-Stage Instructions:

	YES	NO
1. "Point to the pen"		
2. "Pick up the spoon"		
3. "Turn over the glass"		
4. "Give me your hand"		
Reliable? (4/4)	___	___

B. Two-Stage Instructions:

1. "Point to the soap, then pick up the spoon"		
2. "Put the pen to the right of the glass".		
3. "Show me two fingers, then pick up the spoon"		
4. "Give me the soap, then point to the pen"		
Reliable? (4/4)	___	___

C. Three-Stage Instructions:

YES NO

1. "Put the pen in the glass, give me the soap and pick up the spoon"

2. "Pick up the spoon, place it to the left of the soap and turn over the glass"

3. "Point to the window, show me two fingers and close your eyes"

4. "Put the pen between the soap and glass, pick up the spoon and point to your nose"

Reliable?
4/4

II. Graphic Comprehension

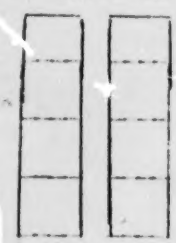
A. Single word (Expose each word one at a time and say: "Read this word and show me where one of these is").

1. GLASS

2. SPOON

3. SOAP

4. PEN



Reliable?
(4/4)

B. Sentences: (Expose each sentence one at a time and say: "Read this sentence and do what it says to do)".

1. Pick up the spoon

2. Show me two fingers

3. Put the spoon between the pen and soap

4. Put the glass to the left of the pen

Reliable?
(4/4)

YES NO

III. Gestural Comprehension

Demonstrate COMB

1. GLASS
2. PEN
3. SOAP
4. SPOON

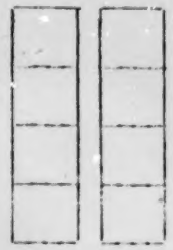
Reliable?
(4/4) ____ ____

ASSESSMENT OF EXPRESSION

I. Verbal Expression

A. Naming: (Pick up each object one at a time and say: "What is the name of this?").

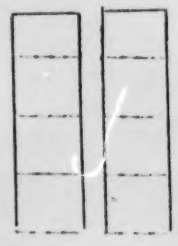
1. GLASS
2. PEN
3. SPOON
4. SOAP



Reliable?
(4/4) ____ ____

B. Describing: (Pick up each object one at a time and say: What is this used for?")

1. SPOON
2. GLASS
3. PEN
4. SOAP



Reliable?
(4/4) ____ ____

II. Graphic Expression

YES NO

A. Naming: (Place the ruled writing paper in front of the subject and put the pencil in his most functional hand. Pick up each object one at a time and say" Write the name of this object on the paper").

1. SOAP
2. PEN
3. SPOON
4. GLASS

Reliable.
(4/4)

B. Describing: (Pick up each object one at a time and say: "Write down on the paper what this object is used for").

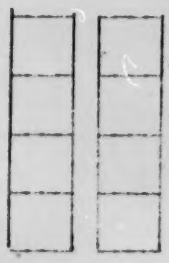
1. SOAP
2. SPOON
3. GLASS
4. PEN

Reliable?
(4/4)

III. Gestural Expressio

Demonstrate COMB

1. SPOON
2. SOAP
3. PEN
4. GLASS



Reliable.
(4/4)

SUMMARY OF RESULTS		Reliable	Unreliable
I. Comprehension			
Verbal:	one-stage	____	____
	two-stage	____	____
	three-stage	____	____
Graphic:	words	____	____
	sentences	____	____
Gestural:		____	____
II. Expression			
Verbal:	naming	____	____
	Describing	____	____
Graphic:	naming	____	____
	describing	____	____
Gestural:		____	____